[redacted]

[redacted],

Petitioner,

v.

CYNTHIA ANN HOLLIDAY,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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BRIEF OF THE NATIONAL CONFERENCE OF STATE LEGISLATURES, NATIONAL LEAGUE OF CITIES, [redacted], NATIONAL ASSOCIATION OF COUNTIES, COUNCIL OF STATE GOVERNMENTS, INTERNATIONAL CITY MANAGEMENT ASSOCIATION, AND U.S. CONFERENCE OF MAYORS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

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QUESTION PRESENTED

Whether the so-called "deemer clause" of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144(b)(2)(B), preempts a state anti-subrogation provision as it applies to a self-insured employee welfare benefit plan.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

No. 89-1048

FMC CORPORATION,
Petitioner,

v.

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BRIEF OF THE NATIONAL CONFERENCE OF STATE LEGISLATURES, NATIONAL LEAGUE OF CITIES, NATIONAL GOVERNORS' ASSOCIATION, NATIONAL ASSOCIATION OF COUNTIES, COUNCIL OF STATE GOVERNMENTS, INTERNATIONAL CITY MANAGEMENT ASSOCIATION, AND U.S. CONFERENCE OF MAYORS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

INTEREST OF THE *AMICI CURIAE*

Amici are organizations whose members include state, county, and municipal governments and officials throughout the United States; they have a compelling interest in legal issues that affect state and local governments.

This case concerns petitioner's contention that the so-called "deemer clause" of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144(b)(2)(B), preempts all state insurance laws as they relate to self-insured employee welfare benefit plans. This contention has enormous importance for the States. If accepted, it would oust the States of a large portion of their au-

thority to regulate insurance, a subject that long has been recognized by Congress and this Court as an area within the States' traditional purview. It also would create wholly irrational distinctions between employees, some of whom (those whose employers offer fully insured plans) would continue to receive the protections of state insurance law, and some of whom (those whose employers self-insure) would lose those protections. *Amici* therefore submit this brief to assist the Court in the resolution of this case.[1]

INTRODUCTION AND SUMMARY OF ARGUMENT

1. This case turns on the preemptive reach of ERISA's so-called "deemer clause," an opaque provision, added to the statute without explanation, that precludes a State from "deem[ing]" an employee benefit plan to be an insurance company (or from "deem[ing]" the plan to be engaged in the business of insurance) for purposes of state laws regulating insurance companies or contracts. 29 U.S.C. § 1144(b)(2)(B). Petitioner and the Solicitor General read the clause as though it provided that all state laws regulating insurance are preempted insofar as they relate to self-insured—but not to fully insured—plans. This reading, however, has no relationship to the actual language of the statute. The deemer clause does not, after all, make any distinction between self-insured and fully insured plans, and it does not, in terms, provide that *all* state insurance laws are superseded as to *all* plans.

In fact, Congress meant exactly what it said in the deemer clause: it wrote the provision to preclude States from "deem[ing]" plans to be insurance companies for purposes of state laws, such as those involving licensing or capitalization, that apply to insurance *as a business*. It is apparent that the clause was drafted in response to the concern, widely discussed at the time of ERISA's enactment, that the States inevitably would drive self-

[1] Both parties' letters of consent pursuant to Rule 37 of the Rules of this Court have been filed with the Clerk of the Court.

insured plans out of existence if they subjected those plans to the licensing, reserve, premium, and filing requirements that state laws impose on insurance companies. Indeed, this concern was given special urgency by a state court judgment, pending on appeal at the time the deemer clause was written, that required a self-insured plan to obtain an operating license from state insurance authorities. In our view, the clause was Congress's response to the problem.

At the same time, Congress did not mean to set aside those aspects of state health and insurance policy that relate to the substance of insurance coverage. This explains the difference in language between the saving and deemer clauses: the former saves any state law regulating "insurance," while the latter is directed at insurance companies and "the business of insurance."

2. Our reading of the deemer clause is consistent with other elements of ERISA, which nowhere distinguishes between self-insured and fully insured plans. And our analysis is wholly faithful to the legislative history. The deemer clause was inserted in ERISA at a time when the preemption clause, which sets the outer limits of preemption, was written in a way that would have superseded only state laws dealing with matters specifically covered by ERISA (such as reporting requirements and fiduciary obligations); at its broadest, the language of the deemer clause accordingly could have been intended to preempt only state laws addressing those areas. In fact, the only specific evidence of the intended application of the ERISA preemption provisions indicates that they were modeled on a statute preempting state laws relating to the creation, management, and structure of health maintenance organizations. The deemer clause was designed to reach the same sorts of laws as they apply to welfare benefit plans.

3. Our reading of the deemer clause also is compelled by the policies that underlie ERISA. Because federal law does not regulate the substance of welfare benefit plans,

petitioner's reading of the clause would (unless the federal courts stepped in to create a federal common law of insurance) leave an enormous regulatory vacuum. That outcome would afford employees less protection than they enjoyed before the enactment of ERISA. Moreover, from the standpoint of plan participants—the people who are the intended beneficiaries of the statute—it is irrelevant whether a plan is self-insured or fully insured; petitioner would distinguish on this wholly irrational basis in determining which employees benefit from the protections of state health insurance law. Against this, petitioner and the Solicitor General argue only that self-insured plans would find it inconvenient to comply with varying state laws. ERISA, however, was enacted not to protect plans, but to " 'promote the interests of employees and their beneficiaries.' " *Firestone Tire & Rubber Co. v. Bruch*, 109 S.Ct. 948, 955 (1989) (citation omitted).

Similar problems inhere in petitioner's contention that the decision below will encourage litigation. In fact, given the regulatory vacuum that would follow from preemption here, the federal courts would have no choice but to create a federal common law of insurance. Yet such a development would engender enormous confusion. Plans would be forced to engage in continuous litigation if their obligations were set by an inchoate body of federal common law that was discovered by the courts on a case-by-case basis. The federal courts, meanwhile, would have to invent rules in an area that has been the traditional province of the States. This Court, moreover, would have no choice but to step in repeatedly to set the contours of the new common law. Such a system, it seems to us, is earnestly to be avoided.

ARGUMENT

I. SECTION 514 OF ERISA DOES NOT PREEMPT PENNSYLVANIA'S ANTI-SUBROGATION LAW.

A. Petitioner's Reading Of The Deemer Clause Cannot Be Reconciled With The Statutory Language.

1. The structure of ERISA's complex preemption provision has become familiar. "If a state law 'relate[s] to . . . employee benefit plan[s],' it is pre-empted. § 514(a). The saving clause excepts from the pre-emption clause laws that 'regulat[e] insurance.' § 514(b)(2)(A). The deemer clause makes clear that a state law that 'purport[s] to regulate insurance' cannot deem an employee benefit plan to be an insurance company. § 514(b)(2)(B)." *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 45 (1987). Although a convincing argument may be made to the contrary, we assume for purposes of our discussion below that Section 1720 of Pennsylvania's Motor Vehicle Financial Responsibility Law, 75 Pa. Cons. Stat. Ann. § 1720 (Purdon 1989), as applied to petitioner, "relate[s] to an employee benefit plan" and therefore is within the scope of the preemption clause.[2] The parties and the So-

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[2] The arguments to the court of appeals were largely directed at the meaning of the deemer clause; we accordingly devote most of our attention to that issue. But those arguments skipped too easily past the preemption clause, for in our view Section 1720 does not "relate to" an ERISA plan within the meaning of that provision. Because the court below considered and addressed this issue at some length (see Pet. App. A13-A15) in response to an *amicus* argument that was expressly endorsed by respondent (see Appellee C.A. Br. 17 n.2), it would be appropriate for this Court to consider the issue as well.

The Court has several times indicated, of course, that " '[a] law "relates to" an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan.' " *Mackey v. Lanier Collection Agency*, 486 U.S. 825, 829 (1988), quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983) (emphasis omitted). See *Pilot Life*, 481 U.S. at 47-48; *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 739 (1985). At the same time, however, the Court has made clear that many state laws—even some that have a direct impact and impose affirmative obligations on plans—do not fall within the scope of the

licitor General agree that the Pennslyvania law also falls within the insurance saving clause. Pet. Br. 11; U.S. Br. 11. The dispositive question here, then, is whether Pennsylvania's statute is preempted by the deemer clause.

In arguing for preemption, petitioner and the Solicitor General read the deemer clause as though it provides that, notwithstanding the saving clause, all state laws involving insurance are preempted insofar as they relate to self-insured—but not to fully insured [3]—welfare benefit plans.

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preemption clause. See *Mackey*, 486 U.S. at 833. Cf. *Shaw*, 463 U.S. at 100 n.21. Indeed, the Solicitor General has conceded in the past that general state tort and contract law may be applied against plans (see *Mackey*, 486 U.S. at 833), and the Court has observed that suits grounded on such laws "are relatively commonplace." *Ibid.* (footnote omitted). See *Rebaldo v. Cuomo*, 749 F.2d 133, 138-139 (2d Cir. 1984).

Relying both on this observation and on ERISA's sue-and-be-sued provision—a type of clause generally understood to authorize "'all civil process[es] incident to . . . legal proceedings'" (*Mackey*, 486 U.S. at 834 n.9 (citation omitted))—the Court has held that general state garnishment rules are not preempted as applied to plans. See *id.* at 841. By the same token, it is plain that normal procedural and claim allocation rules, such as those governing impleader and interpleader, must be applicable to plans in ordinary tort and contract suits. In this light, there can be little doubt that a State's usual subrogation rules, as an element of state tort law that allocates entitlements to tort judgments, should be fully applicable to ERISA plans. If Section 1720 "relates to" a plan, then, it must be because the state law creates a special subrogation rule for the allocation of tort judgments in the setting of liability for automobile accidents. But it is difficult to see why that factor should be dispositive. If subrogation rules do not "relate to" plans when applied to one type of tort judgment, there is, as the Court noted in a very similar setting, "'simply no logical way to construe the English language'" that would make such laws "relate to" plans when applied to another type of tort judgment. *Mackey*, 486 U.S. at 830 (citation omitted).

[3] We use the term "self-insured" to refer to plans that pay benefits out of their own assets; we use the term "fully insured" to refer to plans that purchase coverage for employees from commercial insurance carriers. As we explain below, however, many self-insured plans actually are hybrids, purchasing coverage to protect themselves against excess liability. See page 23, *infra*.

This reading, however, has no relationship to the actual language of the statute. The deemer clause does not, after all, make any distinction between self-insured and fully insured plans, and it does not, in terms, provide that *all* state insurance laws are superseded as to *all* plans. Instead, the clause uses a different and rather curious formulation, providing, as paraphrased by the Court, that a State "cannot deem an employee benefit plan to be an insurance company." *Pilot Life*, 481 U.S. at 45.

Any proper reading of the deemer clause must account for its unusual phrasing. In fact, in our view Congress meant exactly what it said in the deemer clause: as we explain more fully below, it wrote the clause to preclude States from "deem[ing]" plans to be insurance companies for purposes of state laws, such as those involving licensing or capitalization, that apply to insurance *as a business*. At the same time, Congress did not mean to set aside those aspects of state insurance and health policy that relate to the substance of insurance coverage. This reading of the clause, in contrast to petitioner's, has the paramount virtue of "'begin[ning] with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose.'" *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 740 (1985) (citation omitted). Unless there is a compelling reason to depart from it, that language should be the end of the analysis as well.

2. There is no such reason here. To the contrary, our approach, unlike petitioner's, is consistent not only with the terms of the deemer clause, but also with the structure of other elements of ERISA. Petitioner and the Solicitor General acknowledge that their reading distinguishes between self-insured and fully insured plans by allowing for indirect state regulation of the latter; they recognize that, under this Court's holding in *Metropolitan Life*, States may mandate the benefits offered by fully insured plans through regulation of the insurance companies from which the plans purchase their coverage.

ERISA, however, expressly rejects any distinction either between the two types of plans or between direct and indirect state regulation. To the contrary, the pre-emption provisions define "State" to include any entity "which purports to regulate, *directly or indirectly*, the terms and conditions of employee benefit plans." Section 514(c)(2), 29 U.S.C. § 1144(c)(2) (emphasis added). Thus, the "directness" of the regulation should not determine preemption (as it does under petitioner's approach); the inquiry should turn on identifying the range of substantive areas preempted by ERISA. And far from distinguishing between self-insured and fully insured plans, the statute simply defines an "employee welfare benefit plan" as any program that provides medical or similar benefits "through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1). The term "plan" is then used throughout ERISA, as it is in the deemer clause, without distinction between plans that purchase insurance and those that self-insure.[4]

[4] The statute distinguishes between self-insured and fully insured plans at only one point, in an amendment to Section 514 enacted in 1983. 29 U.S.C. § 1144(b)(6). It is instructive to note that the amendment provides (with some exceptions) that multiple employer welfare benefit plans that are *not* fully insured are subject to all state laws regulating insurance (29 U.S.C. § 1144(b)(6)(A)(ii)); such plans that *are* fully insured (or which receive an exemption from the Secretary of Labor) are subject only to state insurance laws regulating reserve and contribution levels. 29 U.S.C. § 1144(b)(6)(A)(i). (The amendment was written to stop abuse of so-called multiple employer health trusts, which sold insurance coverage to many employers but attempted to avoid state regulation as insurance companies by claiming to be ERISA plans. See 128 Cong. Rec. 30,356-30,358 (remarks of Rep. Erlenborn) (1982)). This distinction sensibly allows for *greater* state regulation of self-insured plans that rely on their own resources to meet their obligations to participants, and lesser regulation of fully insured plans that have provided for participants by contracting with established insurance carriers. See 29 U.S.C. § 1144(b)(6)(D). Petitioner would turn this distinction on its head by postulating that participants in self-insured plans need *no* state protections.

B. ERISA's Legislative History Confirms That The Deemer Clause Preempts Only State Laws Directed At The Business Aspects of Insurance.

Our reading of the deemer clause does more than track the statutory language; it also accords with the statute's legislative history, with the underlying purposes of the preemption provisions, and with the overall objectives of ERISA. See generally *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 8-9 (1987). And it indulges the presumption —fully applicable in ERISA litigation but ignored by petitioner and the Solicitor General—"that Congress did not intend to pre-empt areas of traditional state concern." *Metropolitan Life*, 471 U.S. at 740. See *id.* at 741; *Massachusetts v. Morash*, 109 S.Ct. 1668, 1675 (1989); *Fort Halifax*, 482 U.S. at 19; *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981).

1. The three relevant preemption provisions have a complex history. The insurance saving clause was present in its current form in every one of the pension reform bills that led to the enactment of ERISA, dating back to 1970. See *Metropolitan Life*, 471 U.S. at 745 n.23. But neither the existing preemption clause nor any version of the deemer clause was present in the ERISA bills that initially were introduced in either Chamber of Congress.

As introduced in the Senate and reported out of the Committee on Labor and Public Welfare, the bill that ultimately became ERISA contained a limited preemption clause that would have superseded state laws only "insofar as they * * * relate to the subject matters regulated by this Act." S.4, 93d Cong., 1st Sess. § 609(a) (1973), reprinted at 1 Staff of Subcomm. on Labor of the Senate Comm. on Labor and Public Welfare, 94th Cong., 2d Sess., *Legislative History of the Employee Retirement Income Security Act of 1974*, 93, 186 (Comm. Print 1976) [hereinafter *Leg. Hist.*]. See also S. 1557, 93d Cong., 1st Sess. § 18(a) (Finance Committee bill) (1973), reprinted at 1 *Leg. Hist.* 280, 319. As noted above, the bill contained the insurance saving clause in its present form;

it did not contain the deemer clause. See S. 4, *supra*, reprinted at 1 *Leg. Hist.* at 186. See generally S. Rep. No. 127, 93d Cong., 1st Sess. 35 (1973), reprinted at 1 *Leg. Hist.* 587, 621. The Senate approved the bill in this form. See 3 *Leg. Hist.* 3820.

As introduced in the House, the bill that became ERISA contained a more precise but equally limited preemption clause: it would have superseded state laws relating "to the fiduciary, reporting, and disclosure responsibilities of persons acting on behalf of employee benefit plans." H.R. 2, 93d Cong., 1st Sess. § 114 (1973), reprinted at 1 *Leg. Hist.* 3, 50-51. The bill was approved by the Committee on Education and Labor in a slightly modified form. H.R. 2, 93d Cong., 1st Sess. § 514(a) (1973), reprinted at 3 *Leg. Hist.* 2345. Like the Senate version, this bill contained the saving, but no deemer, clause. See *ibid.* See generally H.R. Rep. No. 533, 93d Cong., 1st Sess. 17 (1973), reprinted at 2 *Leg. Hist.* 2348, 2364.

ERISA took a more complex course in the House, however, because the Ways and Means Committee also produced a bill dealing with pension regulation (which contained no preemption provisions at all). See H.R. 12481, 93d Cong., 2d Sess. (1974), reprinted at 2 *Leg. Hist.* 2394. In an attempt to reconcile their efforts, both House Committees produced new and slightly modified substitute bills. See generally 120 Cong. Rec. 4279 (1974) (remarks of Rep. Perkins), reprinted at 2 *Leg. Hist.* 3368-3369.

The deemer clause first appeared, already in its current form, in the substitute for H.R. 2 that emerged from the Education and Labor Committee, where the clause simply was added to the initial preemption and saving clauses. H.R. 12906, 93d Cong., 2d Sess. § 514(b) (1974), reprinted at 2 *Leg. Hist.* 2761, 2961. The Committee did not publish a formal report to accompany this substitute bill, and neither the preemption provisions in general nor the deemer clause in particular were subjects of contention. The only explanation of the entire package of preemption provisions, offered on the House floor, was the con-

clusory statement that "[a]ll States [sic] laws would be pre-empted except for those covering plans not subject to titles II and II [of ERSA]." Remarks of Rep. Perkins (reprinting material in the nature of a Committee report) (Feb. 25, 1974), 3 *Leg. Hist.* 3305. The House passed the bill in this form. See 3 *Leg. Hist.* 4057-4058.

The Conference Committee engaged in extensive redrafting. See Chadwick & Foster, *Federal Regulation of Retirement Plans: The Quest for Parity*, 28 Vand. L. Rev. 641, 669 (1975). In particular, the conferees "broadened the general pre-emption provision from one that pre-empted state laws only insofar as they regulated the same areas explicitly regulated by ERISA, to one that pre-empts all state laws unless otherwise saved." *Metropolitan Life*, 471 U.S. at 745 n.23. See *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 n.19 (1983). As the Court has noted, "[t]he change gave the insurance saving clause a much more significant role, as a provision that saved an entire body of law from the sweeping general preemption clause." *Metropolitan Life*, 471 U.S. at 745 n.23. But "[t]here were no comments on the floor of either Chamber specifically concerning the insurance saving clause, and hardly any concerning the exceptions to the pre-emption clause in general." *Ibid.* See *id.* at 745. The deemer clause was not mentioned at all in the floor debates.

Although the conferees included the deemer clause in the final bill, there was no substantial discussion of the provision's meaning. The only explanation of the Conference Committee's deliberations on the point indicates, rather unhelpfully, that "some of the staff believe[d] [the deemer clause] should be adopted and other staff believe[d] it should not be adopted." *Summary of the Differences Between the Senate Version and the House Version of H.R. 2 to Provide for Pension Reform, Part III* 33 (1974), reprinted at 3 *Leg. Hist.* 5249, 5283. The conference report simply echoed the statutory language. H.R. Conf. Rep. No. 1280, 93d Cong., 2d Sess. 383 (1974),

reprinted at 3 *Leg. Hist.* 4277, 4650. See generally *Metropolitan Life*, 471 U.S. at 745 n.23.

2. This legislative history is worth considering, of course, because "'as in any pre-emption analysis, "the purpose of Congress is the ultimate touchstone."'" *Fort Halifax*, 482 U.S. at 8 (citations omitted). And ERISA's history is illuminating in several respects. At the outset, it demonstrates that a central concern of Congress was preservation of state authority to regulate insurance; the only constant in the statutory evolution, from introduction of the earliest ERISA bills to enactment of the final version of the statute, was the presence of the insurance saving clause. At the same time, there is absolutely no evidence that Congress had an intention to bar States altogether from the regulation of self-insured plans—evidence that one would expect to find were ERISA designed generally to exclude the States from an area within their traditional purview. To the contrary, "[d]espite the volumes of testimony collected during years of congressional hearings, not a word can be found on the subject of preemption of state regulation of self-insured plans." Brummond, *Federal Preemption of State Insurance Regulation Under ERISA*, 62 Iowa L. Rev. 57, 99 (1976) (footnote omitted). See *id.* at 115-116.

Moreover, it is plain from the evolution of ERISA that Congress could not have drafted the language of the deemer clause with the purpose of preempting all state insurance laws as they apply to self-insured plans. As the court below recognized (Pet. App. A20-A21), the deemer clause was put in its current form at a time when the preemption clause applied only to those state laws that dealt with matters specifically covered by ERISA—that is, reporting and disclosure requirements and fiduciary obligations. The language of the deemer clause thus could have been intended, at most, to preempt only state laws addressing those areas. Cf. *Metropolitan Life*, 471 U.S. at 742 n.17.

3. In fact, it seems evident that the deemer clause was directed at a specific and limited problem. At the time

ERISA was enacted, there was some uncertainty about whether self-insured plans generally were subject to state laws regulating the insurance business. Although such plans were becoming common in the 1960s and early 1970s,[5] state insurance commissioners and attorneys general had yet to reach a consensus on whether self-insurers were insurance companies for purposes of laws regulating licensing, reserves, premium taxes, and similar elements of the insurance business;[6] virtually no judicial authority existed on the point.[7] There was concern at the time, however, that treating self-insured plans as insurance companies under state law would effectively drive them out of existence:

> Application of state insurance laws to uninsured plans would make direct payment of benefits pointless and in most cases not feasible. This is because a welfare plan would have to be operated as an insurance company in order to comply with the detailed regulatory requirements of state insurance codes designed with the typical operations of insurance companies in mind. It presumably would be necessary to form a captive insurance company with prescribed capital and surplus, capable of obtaining a certificate of authority from the insurance department of all states in which the plan was 'doing business,' establish premium rates subject to approval by the insurance department, issue policies in the form approved by the insurance department, pay commissions and premium taxes required by the insurance

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[5] See, *e.g.*, Comment, *State Regulation of Noninsured Employee Welfare Benefit Plans*, 62 Geo. L.J. 339, 340 (1973).

[6] See Brummond, *supra*, 62 Iowa L. Rev. at 90-91 & nn. 309-313; Duesenberg, *The Legality of Noninsured Employee Benefit Programs*, 5 B.C. Indus. & Com. L. Rev. 231 (1964); Goetz, *Regulation of Uninsured Employee Welfare Plans Under State Insurance Laws*, 1967 Wis. L. Rev. 319, 323-325.

[7] See Goetz, *supra*, 1967 Wis. L. Rev. at 322-325; Comment, *supra*, 62 Geo. L.J. at 344-346. The only decisions even arguably on point were a few scattered holdings that insurance companies were not liable for premium or similar taxes on self-funded plans that they maintained for their own employees. See note 10, *infra*.

> law, hold and deposit reserves established by the insurance department, make investments permitted under the law, and comply with all filing and examination requirements of the insurance department. The result would be to reintroduce an insurance company, which the direct payment plan was supposed to dispense with. Thus it can be seen that the real issue is not whether uninsured plans are to be *regulated* under state insurance laws, but whether they are to be *permitted*.

Goetz, *Regulation of Uninsured Employee Welfare Plans Under State Insurance Laws*, 1967 Wis. L. Rev. 319, 320-321 (emphasis in original).

These concerns were given added urgency at the time that ERISA was under consideration by the first judicial decision squarely to address the issue, in which a Missouri court held that an employer's self-insured plan was subject to state licensing requirements. *Missouri v. Monsanto Co.*, Cause No. 259774 (St. Louis Cty. Cir. Ct. Jan. 4, 1973), rev'd, 517 S.W.2d 129 (Mo. 1974). The circuit court holding effectively forced the employer to terminate its plan and purchase insurance from a commercial company. See Comment, *State Regulation of Noninsured Employee Welfare Benefit Plans*, 62 Geo. L.J. 339, 345-346 (1973). The decision was pending on appeal during the period that ERISA was under consideration and the deemer clause was drafted.

Against this background, it appears virtually certain that the deemer clause was added in response to the specific concern that self-insured plans would be driven out of existence if they were treated as commercial insurers—if, in the language of the statute, such a plan was "deemed to be an insurance company or other insurer * * * or to be engaged in the business of insurance." The clause thus was concerned with state laws directed at the *business* of insurance, such as those concerning the creation, management, and structure of insurers.[8] Not coincidentally, these were the general areas dealt with by the original version of the ERISA preemption clause (in place when the

deemer clause was drafted), which would have superseded state laws bearing on fiduciary standards for plan management, as well as plan reporting and disclosure requirements.[8] In contrast, the deemer clause was not directed at other forms of state insurance regulation, such as those involving the relationship between the insured and his insurer.[9] This explains the difference in terminology between the saving and deemer clauses: the former makes no mention of insurance companies or of "business," saving "any law of any State which regulates insurance"; the latter provides that an employee benefit plan "shall [not] be deemed to be an insurance company or other insurer * * * or to be engaged in the business of insurance." [10]

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[8] The decision below substantially accords with this analysis. While we would not put the inquiry in terms of "pretext" (see Pet. App. A19-A20) or legislative motive—since States may have substantial, legitimate reasons for treating self-insured plans as insurance companies—the crucial element of the court of appeals' holding was its conclusion that States could not regulate the fiduciary and disclosure obligations of such plans by the simple expedient of labeling them "insurance companies."

[9] Differentiating between these two types of regulation is not difficult; the distinction often is drawn in general descriptions of insurance law. See, *e.g.*, *Metropolitan Life*, 471 U.S. at 727-728.

[10] A similar line had been drawn prior to the enactment of ERISA by state court decisions addressing attempts to impose premium and related taxes on insurance companies for self-funded plans that they maintained for their own employees. As the New York Court of Appeals put it in the leading (and, at the time of ERISA's enactment, most recent) such case, although the agreements between the employer and plan participants were understood to be "'insurance contracts,'" the program "pursuant to which [the company] grants insurance benefits to its employees, is not the doing of an insurance business" because the plan did not "include an amount attributable to profit or contribution to a surplus." *Mutual Life Insurance Co. v. New York State Tax Comm'n*, 298 N.E. 2d 632, 634, 635 (N.Y. 1973). See *Danna v. Commissioner of Insurance*, 228 So.2d 708, 712-713 (La. Ct. App. 1969); *Williams v. Massachusetts Mutual Life Insurance Co.*, 427 S.W.2d 845, 848 (Tenn. 1968); *State Tax Comm'n v. John Hancock Mutual Life Insurance Co.*, 170 N.E.2d 711, 715-717 (Mass. 1960).

Indeed, the Missouri Supreme Court eventually drew exactly this line between "insurance" (the subject of the saving clause) and the "business of insurance" (the subject of the deemer clause) when, after ERISA was signed into law, it reversed the trial court decision in *Monsanto* on state law grounds. In holding that a self-insured plan was not subject to a Missouri law requiring companies to be licensed before " 'transact[ing] in this state any insurance business' " (517 S.W.2d at 131 (citation omitted)), the court explained: "The term 'insurance business' is not statutorily defined, but it is not the same as 'insurance' or the word 'business' would be meaningless. We must assume that the legislature intentionally added the word 'business,' and that the phrase is to be used in its usual and ordinary meaning." *Id.* at 132. The court accordingly held that the self-insured plan was not subject to state laws specifically directed at insurance companies because "it is not in the business of attempting to make either a profit or accumulate a surplus from the operation of its [plan]." *Ibid.* Notwithstanding the Solicitor General's argument to the contrary (Br. 18-19), in our view the Department of Labor has accepted this distinction, specifically endorsing the *Monsanto* approach in an opinion issued shortly after the enactment of ERISA. United States Department of Labor, ERISA Opinion Letter No. 75-128, at 1 (June 20, 1975).[11]

4. This reading of the deemer clause is entirely consistent with other elements of the legislative history. As we note above, the deemer clause, which was written

[11] The other Department of Labor opinions cited by the Solicitor General (Br. 19 n.13) also are consistent with our reading. Two involved state laws directed at the insurance business. ERISA Opinion Letter No. 78-3A (Feb. 15, 1978) (law requiring that plan receive a certificate of authority and comply with disclosure requirements); ERISA Opinion Letter No. 79-6A (Jan. 16, 1979) (law requiring that self-insurers join reinsurance association as a condition of doing business, and imposing taxes on premiums and benefits paid). The third involved a state law that regulated employee benefit plans in terms. ERISA Opinion Letter No. 82-006A (Jan. 29, 1982).

while the preemption clause was narrowly directed at state laws regulating fiduciary and disclosure obligations, could not initially have been placed in the statute to preclude state regulation of self-insured plans in other areas. As for the preemption clause itself, it apparently was broadened not generally to protect self-insured plans from state regulation, but "out of a fear that 'state professional associations' would otherwise hinder the development of such employee-benefit programs as 'pre-paid legal service programs.' " *Metropolitan Life*, 471 U.S. at 745 n.23 (citation omitted).[12]

At the same time, the general statements in the legislative history about the breadth of ERISA preemption, relied upon by petitioner (Pet. Br. 23) and the Solicitor General (U.S. Br. 14), are simply beside the point. Read in context, it is plain that in every case those statements were directed at the *preemption clause*; while they refer to the breadth of ERISA preemption, the statements note the "narrow exceptions [to preemption] specifically enumerated" in the statute. 120 Cong. Rec. 29,197 (1974) (remarks of Rep. Dent), reprinted at 3 *Leg. Hist.* 4670.[13] Because this case concededly falls within one of the "specifically enumerated" exceptions, the insurance saving clause, the remarks cited by petitioner on the scope of the preemption clause are irrelevant.[14] Petitioner's argu-

[12] As the Court noted, "[t]here is no suggestion that the preemption provision was broadened out of any concern about state regulation of insurance contracts, beyond a general concern about 'potentially conflicting State laws.' " *Metropolitan Life*, 471 U.S. at 745 n.23, quoting 120 Cong. Rec. 29,942 (1974) (remarks of Sen. Javits).

[13] See 120 Cong. Rec. 29,933 (1974) (remarks of Sen. Williams) (referring to breadth of preemption "with the narrow exceptions specified in the bill"), reprinted at 3 *Leg. Hist.* 4745-4746; 120 Cong. Rec. 29,942 (1974) (remarks of Sen. Javits) (referring to breadth of preemption "but for certain exceptions"), reprinted at 3 *Leg. Hist.* 4771.

[14] Indeed, in addressing the scope of the exceptions to the preemption clause, the Court has rejected reliance on the "few passing

ments principally serve to emphasize that there were no congressional comments directed to the deemer clause—comments one would expect to find if the clause had a broadly preemptive effect.

Indeed, in contrast to the boilerplate references to the breadth of the preemption clause cited by petitioner, the one specific indication of how Congress intended the preemption provisions to apply supports our reading. Representative Dent, floor manager for the bill in the House and a member of the Committee that produced the deemer clause, explained that ERISA's preemption provisions "followed to a large extent the same approach as in Public Law 93-222 * * * where the regulation of health maintenance organizations [HMOs] was foreclosed to State authority—section 113(a) [sic]."[15] 120 Cong. Rec. 29,197 (1974) (remarks of Rep. Dent), reprinted at 3 *Leg. Hist.* 4670. The statute to which Representative Dent referred as the model for ERISA preemption—which had been enacted in December 1973, around the time the deemer clause was written—preempted state laws relating to the creation and organization of HMOs; in particular, it superseded state requirements that HMOs satisfy the capitalization and reserve obligations imposed on insurance businesses. Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, § 1311(a), 87 Stat. 914, 931 (Dec. 29, 1973).[16] But the statute did not preempt state laws addressing the relationship between HMOs and their

references" to the narrowness of the exceptions. *Metropolitan Life*, 471 U.S. at 746.

[15] Congressman Dent in fact had in mind Section 1311(a).

[16] The statute thus preempted laws requiring medical society approval for the creation of HMOs, requiring that physicians constitute a defined percentage of an HMO's governing body, requiring that all or a percentage of physicians in the locale be permitted to participate in providing services for the HMO, or requiring that the HMO meet the "requirements for insurers of health care services doing business in that State respecting initial capitalization and establishment of financial reserves against insolvency." 87 Stat. 931.

participants. In our view, that is precisely the line drawn by the deemer clause as well.

5. Perhaps because there is so little that is helpful to their case in the contemporaneous legislative history, petitioner and the Solicitor General rely on post-enactment legislative developments. We also could point to post-enactment history.[17] But extensive consideration of this history simply is not fruitful, since the Court repeatedly has made clear in the ERISA setting that "'[t]he views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one.'" *Firestone Tire & Rubber Co. v. Bruch*, 109 S.Ct. 948, 956 (1989) (citation omitted). See, *e.g.*, *Mackey*, 486 U.S. at 840.

Petitioner and the Solicitor General place principal reliance (Pet. Br. 12 n.7; U.S. Br. 17 n.11) on a post-enactment Committee report, also mentioned by this Court in *Metropolitan Life*, 471 U.S. at 747 n.25, that was written in 1977 and did not accompany legislation. H.R. Rep. No. 1785, 94th Cong., 2d Sess. (1977). On examination, it is not at all clear that the Committee's statements are inconsistent with our reading of the deemer clause.[18] But

[17] At hearings in 1978, for example, "Senator Lloyd Bentsen, the chief drafter of ERISA in the Senate Finance Committee * * * stated that the Finance Committee did not deal with the question of preempting health insurance." 128 Cong. Rec. 30,354 (1982) (remarks of Rep. Burton, reprinting statement of Sen. Matsunaga).

[18] The Solicitor General notes (Br. 17 n.11) the Committee's statement that "the 'deemed' language was utilized to create an irrebuttable presumption that these [benefit] plans are not insurance, trust companies, etc., for purposes of state regulation." H.R. Rep. No. 1785, 94th Cong., 2d Sess. 47 (1977). This, of course, is precisely our understanding of the deemer clause. The Solicitor General (Br. 17 n.11) and petitioner (Br. 12 n.7) also point (with several misleading ellipses) to the Committee's observation that, "[t]o the extent that such programs fail to meet the definition of an 'employee benefit plan,' state regulation of them is not preempted by section 514, even though such state action is barred with respect to the plans which purchase these 'products.'" H.R. Rep. No. 1785, *supra*, at 48. The "programs" referred to by the Committee were those offered by entrepreneurs who sold insurance coverage

in any event, "it is the function of the courts and not the Legislature, much less a Committee of one House of the Legislature, to say what an enacted statute means." *Pierce v. Underwood*, 108 S.Ct. 2541, 2551 (1988). See *Mackey*, 486 U.S. at 840.

Indeed, the wisdom of this rule is especially manifest here, for the report's authors plainly had an imperfect understanding of the operation of ERISA's preemption provisions. The report thus explains that the exceptions to the preemption clause "are designed to delineate affirmatively the limits of the 'field' preempted by section 514(a), and articulate a second, but distinctly subordinate, policy within the section of preserving state authority *insofar as it does not relate to any plan* * * *." H.R. Rep. No. 1785, *supra*, at 47 (emphasis added); see *id.* at 46. As Judge Merritt explained for the Sixth Circuit, however, "[t]hese subsequent legislators (or their staff) did not seem to recognize or consider the fact that the 'savings' clause would not be necessary at all if it only saves state laws that do not 'relate to' ERISA plans. The savings clause would not be necessary to save something that the preemption clause had not reached in the first instance." *Northern Group Services, Inc. v. Auto Owners Insurance Co.*, 833 F.2d 85, 89 (6th Cir. 1987), cert. denied, 108 S.Ct. 1754 (1988). Since the authors of the Committee report failed to grasp the application of

(or "products") to employers and employees at large, while seeking to escape state regulation by claiming to be ERISA plans. The Committee's statement expressed the view that such programs were not plans within the meaning of the statute and therefore were subject to state regulation as insurance companies. The bona fide plans that purchased coverage from these programs, of course, could not be treated as—or "deemed" to be—insurance companies, and therefore could not be subjected to state regulation of the business of insurance. Whether the plans might be subjected to other forms of insurance regulation simply was not addressed by the Committee. (Congress ultimately amended Section 514 to make clear that entrepreneurial programs providing insurance to many employers, often referred to as multiple employer health trusts, were subject to full state regulation. See note 4, *supra*.)

the saving clause, there is no reason to suppose that they had a firm appreciation for the substance of the deemer clause. Cf. *Rebaldo v. Cuomo*, 749 F.2d 133, 137 n.1 (2d Cir. 1984) (another portion of report's preemption discussion "lack[s] even persuasive authority").[19]

C. Preemption Of All State Insurance Regulation As Applied To Self-Insurers Would Run Counter To The Policies Of ERISA.

Our reading of the deemer clause also is faithful to the fundamental policies that underlie ERISA—policies that petitioner and the Solicitor General entirely disregard. ERISA was enacted to correct abuses in the administration of pension plans, and generally "to safeguard employees from the abuse and mismanagement of funds that had been accumulated to finance various types of employee benefits." *Morash*, 109 S.Ct. at 1671. The statute accordingly imposes substantive requirements on pension plans in the areas of funding, vesting, participation,

[19] The Solicitor General also points (Br. 17 n.11) to a 1983 amendment, enacted in response to a decision of the Ninth Circuit, that exempts portions of a Hawaii mandatory health benefits law from preemption under ERISA. Act of Jan. 14, 1983, Pub. L. No. 97-473, § 301(a), 96 Stat. 2605, 2611, codified at 29 U.S.C. § 1144 (b)(5). The Solicitor General finds this amendment significant because it exempts only a single state law. In explaining the amendment, however, the Senate Committee indicated that "the preemption of the Hawaii [statute] by ERISA was inadvertent" (S. Rep. No. 646, 97th Cong., 2d Sess. 18 (1982))—hardly a ringing assertion that ERISA as originally enacted had been designed broadly to preempt state health insurance laws. Not surprisingly, the Court rejected the Solicitor General's essentially identical argument from post-enactment history in *Mackey*, 486 U.S. at 839-840. For its part, the Conference Committee in 1983 seemed to believe that the preemption clause reaches only state laws that address matters within the substantive scope of ERISA, stating that the amendment "continues Federal preemption of State law with respect to matters governed by the reporting and disclosure and the fiduciary responsibility provisions of ERISA, as well as certain of the provisions of the administration and enforcement rules of ERISA." H.R. Conf. Rep. No. 984, 97th Cong., 2d Sess. 18 (1982). If this post-enactment history is relevant at all, it plainly is not inconsistent with the holding below. See generally *Mackey*, 486 U.S. at 839-840.

and plan termination. See 29 U.S.C. §§ 1052-1086, 1301-1461. See generally *Alessi*, 451 U.S. at 510-511 & nn. 5-7; *Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 374-375 (1980). But welfare benefit plans are not subject to these requirements (see 29 U.S.C. §§ 1051(1), 1081(1)), or to any other comprehensive federal regulation; while ERISA imposes fiduciary and disclosure requirements on the managers of all plans, it "does not regulate the substantive content of welfare-benefit plans." *Metropolitan Life*, 471 U.S. at 732. See generally *Shaw*, 463 U.S. at 91.

Federal law thus provides no regulation of the substance of welfare plans; the universal preemption that petitioner finds in the deemer clause would sweep away the protections of state insurance and health policy as well. Unless the federal courts stepped in to create a federal common law of insurance—a possibility we discuss below—the result of petitioner's approach accordingly would be "a vast regulatory vacuum." Brummond, *supra*, 62 Iowa L. Rev. at 118. See *id.* at 100. That outcome, as the Court has noted in a similar setting, "would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." *Firestone*, 109 S.Ct. at 956. See *Morash*, 109 S.Ct. at 1675. It is impossible to imagine that Congress intended such consequences from a statute "enacted 'to promote the interests of employees and their beneficiaries in employee benefit plans.'" *Firestone*, 109 S.Ct. at 955, quoting *Shaw*, 463 U.S. at 90.

Petitioner's interpretation of the deemer clause would have other anomalous consequences as well. From the standpoint of plan participants—the people who are the intended beneficiaries of ERISA—it is irrelevant whether a plan is self-insured or fully insured; that is a matter of their employer's accounting convenience. Yet petitioner would distinguish on this wholly irrational basis in determining which participants benefit from the protections of state insurance law.

Indeed, petitioner's approach would create irrational distinctions even within plans. Many self-insured plans enter into so-called "stop loss" agreements with insurance carriers, in which the carriers agree to pay individual claims that exceed a certain amount, or to assume all liability for claims once the plan's aggregate insurance obligations exceed a specified limit. See Brummond, *supra*, 62 Iowa L. Rev. at 92. These insurance carriers are of course subject to state insurance laws. See *ibid.* Thus, under petitioner's reading of the deemer clause, all of the State's substantive insurance regulations (such as the anti-subrogation provision at issue here) would become fully applicable to a plan that had entered into a stop loss agreement once the plan's coverage limits had been reached and the insurance carrier assumed liability. Whether state law applied to a particular participant's claim therefore would turn on whether the claim was filed before or after total claims reached the coverage limit. Again, it is impossible to imagine that Congress meant the deemer clause to create such a system.[20] See *Shaw*, 463 U.S. at 107-108.

2. Against all of this, petitioner (Pet. Br. 27-29) and the Solicitor General (U.S. Br. 25-27) offer a single argument from the policy and history of the statute: that self-insured plans would find it inconvenient to comply with varying state laws. But this concern is substantially overstated.

The argument for preemption on grounds of administrative convenience relies in large part on fragments of the floor debate indicating that the preemption clause was aimed at "eliminating the threat of conflicting and inconsistent state and local regulation." 120 Cong. Rec. 29,197 (1974) (remarks of Rep. Dent), reprinted at 3 *Leg. Hist.* 4670. See *id.* at 29,942 (remarks of Sen. Javits), reprinted at 3 *Leg. Hist.* 4770-4771; *id.* at 29,933

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[20] Similar interpretive anomalies arise in plans—like petitioner's—that hire insurance companies to administer and process claims. See Brummond, *supra*, 62 Iowa L. Rev. at 92.

(remarks of Sen. Williams), reprinted at 3 *Leg. Hist.* 4745-4746. As we explain above, however, the floor debate was largely directed at the preemption clause. This case, in contrast, falls within the insurance saving exception to that clause; and, as the Court has explained, "disuniformities * * * are the inevitable result of the congressional decision to 'save' local insurance regulation. Arguments as to the wisdom of these policy choices must be directed at Congress." *Metropolitan Life*, 471 U.S. at 747.[21]

In any event, petitioner fundamentally misses the point of ERISA. The statute was not enacted to protect plans or employers; it was designed to safeguard employees and their beneficiaries. *Firestone*, 109 S.Ct. at 955; *Shaw*, 463 U.S. at 90. See 29 U.S.C. § 1001(b); *Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. 211, 214 (1986); *Central States Pension Fund v. Central Transport, Inc.*, 472 U.S. 559, 569 (1985).[22]

With this in mind, in an area where Congress did not set out applicable minimum standards, concerns for administrative convenience cannot overcome the far more fundamental interest in the protection of plan participants. After all, "one 'uniform rule'"—the rule contended for by petitioner—"would be simply to defer willy nilly to the provisions of the ERISA plan, an obviously arbitrary result that would allow the plan trustees to decide every issue in their own favor without judicial

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[21] Moreover, in the context of a debate over preemption, it seems plain that Congress's principal concern was with state rules that conflicted or were inconsistent with the *federal* law establishing uniform fiduciary and disclosure requirements.

[22] See, *e.g.*, S. Rep. No. 127, 93d Cong., 1st Sess. 1, 13-14 (1973), reprinted at 1 *Leg. Hist.* 587, 599-600; H.R. Rep. No. 533, 93d Cong., 1st Sess. 1 (1973), reprinted at 2 *Leg. Hist.* 2348; 120 Cong. Rec. 29,192 (1974) (remarks of Rep. Perkins), reprinted at 3 *Leg. Hist.* 4657; *id.* at 29,195, 29,196 (remarks of Rep. Dent), reprinted at 3 *Leg. Hist.* 4665, 4668; *id.* at 29,928 (remarks of Sen. Williams), reprinted at 3 *Leg. Hist.* 4733; *id.* at 29,933, 29,935, 29,943 (remarks of Sen. Javits), reprinted at 3 *Leg. Hist.* 4747, 4751, 4775.

review." *Northern Group*, 833 F.2d at 94. But it is hardly likely that Congress meant to establish that sort of uniform rule by abrogating all protections for welfare plan participants. Indeed, in a number of contexts this Court has rejected the contention that the prospect of increased administrative or litigation costs justifies the preemption of state law under ERISA. See *Firestone*, 109 S.Ct. at 956; *Mackey*, 486 U.S. at 831-832; compare *id.* at 843-844 (Kennedy, J., dissenting).

It is worth adding that petitioner substantially overstates the inconvenience and expense of preserving state laws such as the anti-subrogation provision at issue in this case. As Congress was informed in 1982, when it enacted the exemption for Hawaii's mandatory health insurance law upon which the Solicitor General relies (see note 19, *supra*):

> [A]ny employer using an automated payroll would not encounter any difficulty or extraordinary cost in meeting different state health care requirements for the following reasons: First, medical benefits are fairly uniform nationwide. Second, payroll offices using automated systems can easily cope with any variations as they do with existing differences for pay packages for workers in different states * * *. If all 50 states developed varying health insurance programs, * * * experts were fairly confident that a computer program could deal with varying benefit packages.

128 Cong. Rec. 30,354 (1982) (remarks of Rep. Burton, reprinting testimony of Sen. Matsunaga). See *id.* at 30,355 (remarks of Rep. Burton, reprinting testimony of Sen. Matsunaga) (noting the "minimal cost" of coping with variations in state law).

3. Petitioner and the Solicitor General similarly argue that their reading of the deemer clause will forestall litigation about the applicability of particular state laws. But it is their analysis, in our view, that would create both considerable uncertainty in the law and a concomitant increase in litigation.

Petitioner seems to assume that preemption would leave it free of all regulation, federal and state. As the Solicitor General candidly acknowledges, however (U.S. Br. 4 n.2), both Congress and this Court have made it clear that, in areas where state law is preempted, "courts are to develop a 'federal common law of rights and obligations under ERISA-regulated plans.'" *Firestone*, 109 S.Ct. at 954, quoting *Pilot Life*, 481 U.S. at 56. See also *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1, 24 n.26 (1983); 120 Cong. Rec. 29,942 (1974) (remarks of Sen. Javits), reprinted at 3 *Leg Hist.* 4771. Given the enormous regulatory vacuum that would follow from preemption here, the federal courts would have no choice but to create a federal common law of insurance to resolve questions about, for example, what rule of subrogation to apply. See U.S. Br. 4 n.2.

Such a system would invite confusion and uncertainty. "Over the years states * * * have developed a substantial and complex body of [insurance] law and statutory principles to resolve questions of priority. * * * This corpus of law embodies principles of restitution and risk allocation that have evolved from acquired state experience and expertise." *Northern Group*, 833 F.2d at 94. If state law is not preempted, affected plans may readily determine their obligations by reference to these rules. But that will be impossible if the controlling principles must be found in an inchoate body of federal common law that is discovered by the courts on a case-by-case basis. Giving the federal courts such extensive law-making powers in an area that is not touched substantively by ERISA would make extensive litigation inevitable.

It also would require federal courts to assume a role for which they are profoundly ill-suited. Insurance law has, of course, traditionally been the province of the States. Federal courts accordingly have no experience in applying or developing its principles. And in an area —such as the one involved here—that is not addressed by ERISA, the federal courts would be forced to develop rules "uninformed by any well-defined independent federal interest." *Northern Group*, 833 F.2d at 94. This Court, moreover, would be obligated to step in repeatedly to set the contours of the new federal common law of insurance. Such a system, it seems to us, is earnestly to be avoided.

D. This Court's Opinion In *Metropolitan Life* Does Not Mandate Preemption.

In fact, petitioner and the Solicitor General principally rely not on the statutory language, which they barely mention, or on the legislative history, which they set out only in passing. Instead, their argument in large part is grounded on brief snippets taken from this Court's opinion in *Metropolitan Life*. See Pet. Br. 14-16; U.S. Br. 15-18. In particular, they point to two of the Court's statements: the observation that the saving clause must reach laws regulating insurance contracts because otherwise "it would have been unnecessary for the deemer clause explicitly to exempt such laws from the saving clause when they are applied directly to benefit plans" (471 U.S. at 741); and the statement that the Court's analysis "results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not." *Id.* at 747 (footnote omitted).

These comments cannot bear the weight that petitioner and the Solicitor General place upon them. Both statements are, in fact, literally consistent with our reading of the deemer clause. Under our approach the deemer clause remains necessary to preempt state laws regulating insurance contracts as those laws apply to the *business* of insurance (such as premium levels, commissions, and so on). See pages 15-16 & n.10, *supra*. And it remains true under our understanding of the deemer clause that laws directed at insurance companies—those relating to reserves, premiums, and so on—will have an indirect impact on insured plans but will be inapplicable to self-insured plans.

Having said that, we recognize that there is some tension between a broad reading of these comments from *Metropolitan Life* and the holding below. But that tension should not be dispositive here, for the statements cited by petitioner and the Solicitor General were not essential to the Court's holding in *Metropolitan Life*. As the Solicitor General elliptically acknowledges (U.S. Br. 16), the issue before the Court in *Metropolitan Life* did not involve the application of the deemer clause to a self-insured plan; instead, it concerned the application of the saving clause to an *insurance company*. Thus, as the Court put it, "[t]he narrow statutory ERISA question presented [in *Metropolitan Life*] is whether [the state law at issue] is a law 'which regulates insurance' within the meaning of" the saving clause. 471 U.S. at 738. Indeed, the State had made no attempt to enforce the state law at issue in *Metropolitan Life* against self-insured plans. *Id.* at 735 n.14.

In these circumstances, the Court should not find the most expansive reading of its statements in *Metropolitan Life* to be controlling now. Indeed, the Court already has declined to give force to the broadest interpretation of language taken from *Metropolitan Life* in a case, like this one, that presented issues "the Court had no occasion to consider in *Metropolitan Life*." *Pilot Life*, 481 U.S. at 57. It would be appropriate for the Court to follow the same course here and consider the question in this case with a fresh eye.

II. IF STATE LAW IS PREEMPTED, FEDERAL COURTS SHOULD ADOPT THE STATE RULE AS THE FEDERAL RULE OF DECISION.

Finally, it should be emphasized that even if the Court disagrees with our reading of the deemer clause and finds that federal law is controlling here, that is not the end of this case. As we explain above, the courts still would have to formulate the applicable rule of federal common law. While that task properly is left to the lower courts on remand, in our view it would be appropriate

for those courts to adopt state law as the federal rule of decision. We accordingly urge the Court (if it finds pre-emption in the first instance) not to foreclose that as a possibility on remand.

It is, of course, "possible to 'adopt,' as the operative 'federal' law, differing laws in the different States, depending upon the State where the relevant transaction takes place." *United States v. Yazell*, 382 U.S. 341, 356-357 (1966) (citation omitted). In particular, "when there is little need for a nationally uniform body of law, state law may be incorporated as the federal rule of decision." *United States v. Kimbell Foods, Inc.*, 440 U.S. 715, 728 (1979). That may be so even when federal law is made applicable by a statute that preempts the field. See, *e.g.*, *International Union v. Hoosier Cardinal Corp.*, 383 U.S. 696, 701-703 (1966).

Certainly, uniformity is essential in areas where ERISA sets a discernible federal policy. But there is no federal interest in any particular rule governing the subrogation rights of welfare benefit plans, and thus no interest derived from ERISA's policies that mandates application of a uniform national rule. Cf. *Northern Group*, 833 F.2d at 94. The only argument for uniformity offered by petitioner is its contention that it would be burdensome for plan managers to learn the insurance laws of the various States in which they operate. We note that this interest, even if substantial, gives the court no guidance in choosing which uniform rule to apply. But in any event, administrative convenience is not an adequate reason to set aside an entire body of state law: "[t]hough a uniform [rule] might well constitute a desirable statutory addition, there is no justification for the drastic sort of judicial legislation" sought by petitioner. *Hoosier Cardinal Corp.*, 383 U.S. at 702-703. See *Yazell*, 382 U.S. at 353; *United States v. Brosnan*, 363 U.S. 237, 241-242 (1960).[23]

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[23] It should be added that the rule of complete subrogation contended for by petitioner is not desirable as a matter of policy. At a

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

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minimum, as the Solicitor General notes (Br. 4 n.2), petitioner should not be permitted to obtain full reimbursement out of respondent's tort settlement if respondent has not been made whole for her medical expenses, a point on which the record is silent. See U.S. Br. 3 n.1. But beyond that, respondent's tort suit included claims both for medical expenses and for pain and suffering; given the extent of her injuries, the latter claim surely was substantial. Some (if not all) of the tort settlement, which amounted to only a fraction of respondent's claim, therefore plainly reflected recovery for pain and suffering. Allowing the insurer to obtain this recovery to cover its outlays for medical expenses "would require diversion of the insured's recovery for * * * pain and suffering and [would] completely deplete the insured's recovery for damages. It would also allow the insurer to recover 100% of its expenditure while the insured only recovered [a fraction] of [her] damages." *Allstate Insurance Co. v. Clarke*, 527 A.2d 1021, 1025 n.5 (Pa. Super. Ct. 1987). In such circumstances, "[t]here would be nothing equitable in awarding the entire [settlement] to the medical insurer." *Ibid.* If sound policy and equity are to underlie a controlling common law rule, on remand the courts below should be free to reject petitioner's approach.